



Physical Therapy Credentialing  
P.O. Box 47877  
Olympia, WA 98504-7877  
360-236-4700

## Board of Physical Therapy Request for Spinal Manipulation Endorsement

Complete section one below and then forward to your clinical supervisor for completion of section two and three. This form may be duplicated if you have more than one clinical supervisor. You may not serve as your own clinical supervisor.

### 1. To be completed by the applicant:

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ WA State License Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

E-mail Address \_\_\_\_\_

If the address currently on record with the Department of Health is different from the address provided above, would you like your address of record updated? ☐ Yes ☐ No

### Education and Training:

I have completed the following training as required under [RCW 18.74.190](#) and [WAC 246-915-380\(1\)](#):

- ☐ One year of full-time, orthopedic, postgraduate practice experience that consists of direct patient care, averaging at least 36 hours a week; **and**
- ☐ Training in differential diagnosis of no less than 100 hours outlined within a course curriculum; **and**
- ☐ Didactic and practical training related to the delivery of spinal manipulative procedures of no less than 250 hours clearly delineated and outlined in a course curriculum; **and**
- ☐ Specific training in spinal diagnostic imaging of no less than 150 hours outlined in a course curriculum; **and**
- ☐ At least 300 hours of supervised clinical practical experience in spinal manipulative procedures.
- ☐ I completed these hours within 18 months of completing the last three items above; or, if I completed the last three items above before July 1, 2015 my clinical practical experience was completed by January 1, 2017.

I, \_\_\_\_\_, declare under penalty of perjury under that laws of the state of Washington that the foregoing is true and correct. I understand that the Department may request additional information, if it is needed, to evaluate the application.

Applicant Signature: \_\_\_\_\_

Date and City: \_\_\_\_\_

## 2. To be completed by the clinical supervisor(s):

Please select the item that indicates how you qualify as a clinical supervisor in accordance with [RCW 18.74.190](#) and [WAC 246-915-380\(1\)](#).

☐ Washington State Licensed Physical Therapist with a spinal manipulation endorsement.

License number \_\_\_\_\_ ; or

To qualify as a clinical supervisor with an advanced certification or endorsement, a person must be a licensed physical therapist who holds an endorsement or advanced certification for which the training requirements are commensurate with the training requirements in [WAC 246-915-380\(1\)\(a\)-\(d\)](#) as provided in [WAC 246-915-382](#).

☐ Advanced Certification (Identify) \_\_\_\_\_;

Physical Therapy license number \_\_\_\_\_ ; or

☐ Licensed Chiropractor.

License number \_\_\_\_\_ ; or

☐ Licensed Osteopathic Physician and/or Surgeon.

License number \_\_\_\_\_

## 3. Supervision of Applicant:

I provided the applicant with supervised clinical practical experience in the amount of \_\_\_\_\_ hours.

I, \_\_\_\_\_, declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct. I understand that the Department may request additional information, if it is needed, to evaluate the application of the individual named on this document.

Clinical Supervisor Signature: \_\_\_\_\_

Date and City: \_\_\_\_\_